Mental Health Association in Indian River County Walk-In Center Intake Form: Child/Teen

Child's Name: _____ Date: _____
(First) (Middle Initial) (Last)

How did you hear about us? ☐ 211 ☐ Behavioral Health Center ☐ Childcare Resources
☐ Connections Center ☐ CORE/Probation ☐ Clerk of the Court ☐ DCF ☐ Healthy Start
☐ Doctor:_____ ☐ Family ☐ Friend ☐ Health Department
☐ Hospital/Emergency Room ☐ Insurance Company: _____ ☐ Mental Health Court
☐ Social Media ☐ Newspaper/Magazine ☐ Radio ☐ Return Client ☐ School: _____
☐ Self ☐ Victims Advocacy ☐ Vocational Rehabilitation ☐ Website ☐ Google
☐ Other: _____

Before today's visit, did you speak with a member of our clinical team by phone? ☐ Yes ☐ No

Child's SS#: _____ Child's DOB: _____ Child's Age: _____ Child's Gender: _____
Child's Address: _____
(Street) (Apt.) (City) (Zip code)
County: ☐ Indian River ☐ St. Lucie ☐ Martin ☐ Brevard ☐ Other:_____
Child lives with: ☐ Both Parents ☐ Father ☐ Mother ☐ Other: _____
Parents' status: ☐ Married ☐ Never married ☐ Divorced (custody paperwork is needed) ☐ Separated
Are both parents aware of treatment needs of child? ☐ Yes ☐ No Any custody/court order? ☐ Yes ☐ No

Your Name: _____
(First) (Middle Initial) (Last)
Relationship to Child: ☐ Father ☐ Mother ☐ Stepparent ☐ Legal Guardian (proof of guardianship required)
Email: _____
Address: ☐ Same as child's ☐ As follows:
_____ County: _____
(Street) (Apt.) (City) (Zip code)
Home Phone: _____ Work Phone: _____
Cell Phone: _____ Preferred contact #: ☐ Home ☐ Mobile ☐ Work
Can we leave a message? ☐ Yes ☐ No Email: _____

Other Parent or Guardian's Name: _____
(First) (Middle Initial) (Last)
Relationship to Child: ☐ Father ☐ Mother ☐ Stepparent ☐ Legal Guardian (proof of guardianship required)
Address: ☐ Same as child's ☐ As follows:
_____ County: _____
(Street) (Apt.) (City) (Zip code)
Home Phone: _____ Work Phone: _____
Cell Phone: _____

Child's Current Grade: _____ School: _____
Child's race/ethnicity: _____ Estimated Gross Annual Income of Child's Household: _____
Does your child have health insurance coverage? ☐ No ☐ Yes Name: _____
Is your child a US citizen? ☐ Yes ☐ No
Who lives in child's household?_____ Ages of Children in home:_____
Briefly describe need for service: _____

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Are you seeking care due to an accident (auto, home, work, slip/fall) or symptoms due to an accident? ☐ Yes ☐ No
What services for your child are you looking for? ☐ Community Resources ☐ Counseling ☐ Group Therapy
☐ Parenting support ☐ Psychiatric Evaluation ☐ Psycho-educational Testing ☐ Psychotropic Medication
Has your child or family ever received our services? ☐ No ☐ Yes Describe _____
Has your child ever been diagnosed? ☐ No ☐ Yes Diagnosis: _____
Does your child have a therapist/counselor ☐ No ☐ Yes Name: _____
Do your child have a prescriber for mental health meds? ☐ No ☐ Yes Provider: _____

Current Medication Taken by Child	Dosage & Times per Day	Why Taken?	Who prescribes?

Has your child ever threatened/attempted suicide ☐ Yes ☐ No (If yes, # of attempts____ # of threats ____)
Describe:_____
Has your child ever been Baker Acted or Psychiatrically Hospitalized or in Inpatient Care? ☐ Yes ☐ No
Describe:_____
Has your child had outpatient treatment (individual /group therapy, counseling, psychiatry)? ☐ Yes ☐ No
Describe:_____
Does your child or family have pending/current legal issues (charges, court, custody, DCF)? ☐ Yes ☐ No
Describe:_____
Does your child have access to any weapons? ☐ Yes ☐ No Describe: _____
(Our office is a weapon free environment. No weapons of any kind can be brought on site.)
Does your child share/report/display current harm to self? ☐ Yes ☐ No
Describe:_____
Does your child share/report/display current harm to anyone else? ☐ Yes ☐ No
Describe: _____
Do you have any concerns about alcohol or drug use by your child? ☐ N/A ☐ Yes ☐ No
Describe: _____
Does your child have medical problems affecting mental health? ☐ N/A ☐ Yes ☐ No
Describe: _____
Does your child or family have current stressors affecting mental health? ☐ N/A ☐ Yes ☐ No
Describe: _____
Has your child had a recent experience which was traumatic? ☐ Yes ☐ No
Describe: _____
Are you and your child safe in your current environment? ☐ Yes ☐ No Describe concerns: _____
_____
Child's Height: _____ Child's Weight: _____
Child's current eating habits (Check all that apply): ☐ Healthy food choices ☐ Poor food choices
☐ 3 meals a day ☐ 2 meals a day ☐ Skipping meals ☐ Decreased appetite ☐ Overeating ☐ Purging
Child's current sleeping habits (Check all that apply): ☐ Restful ☐ 8 hrs. or more ☐ 8 hrs. ☐ 6-8 hrs.
☐ 4-6 hrs. ☐ Can't sleep ☐ Trouble falling asleep ☐ Toss and turn ☐ Nightmares ☐ Oversleeping

What has helped with the concerns you described (or what has helped in the past)?

_____
_____
_____

Signature		Date	

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